"It's a mixture of fear and anger": Experiences of obstetric violence in the countryside of Alagoas

Vanessa Vitória Silva Ferreira[1]
Amanda Alves dos Santos[2]
Lázaro Batista[3]

Abstract

This article sought to understand the nuances of obstetric violence through everyday accounts of women from the Alagoas agreste. It is based on an intersectional understanding of this phenomenon, recognizing it as multifaceted and expressed in various ways. Methodologically, it utilized virtual discussion circles with a group of women, and for analytical purposes, it employed the assumptions of the intersectional analytical tool combined with aspects of content analysis. The results highlight the experiences lived by the women, which indicate a lack of knowledge regarding the topic, the micro and macropolitical forms of violent power exertion, and their psychosocial repercussions for the victims. From this, we advocate for the expansion of discussions on obstetric violence in light of the intersectional aspects that characterize it. Also, the need to expand the possibilities of listening to victims of violence and the recognition of their numerous violations, in order to promote the empowerment of their stories.

Keywords

Obstetric Violence; Intersectionality; Women.

"É uma mistura de medo e raiva": experiências de violência obstétrica no agreste alagoano

Resumo

O presente artigo buscou conhecer nuances da violência obstétrica a partir de relatos cotidianos de mulheres do agreste alagoano. Ele parte de uma compreensão interseccional sobre esse fenômeno, reconhecendo-o como multifacetado e de expressão diversa. Metodologicamente, recorreu-se a rodas de conversa virtuais com um grupo de mulheres e, para efeitos de análise, utilizou-se pressupostos da ferramenta analítica da interseccionalidade combinados com aspectos da análise de conteúdo. Como resultados, são apontadas as experiências vivenciadas pelas mulheres, as quais indicam o desconhecimento a respeito do tema, as formas micro e macropolíticas de exercício de poder violento e suas repercussões psicossociais para as vítimas. A partir disso, advogamos pela ampliação dos debates sobre violência obstétrica à luz dos aspectos interseccionais que a caracterizam. Também, a necessidade de ampliar as possibilidades de escuta das vítimas de violências e o reconhecimento de suas inúmeras violações, em busca de promover o empoderamento de suas histórias.

Palavras-chave

Violência Obstétrica; Interseccionalidade; Mulheres.

[1] Psicóloga, graduada pela Universidade Federal de Alagoas (UFAL), Unidade Palmeira dos Índios; Mestranda em Psicologia pela UFAL. E-mail: vanessa.ferreira@arapiraca.ufal.br.

[2] Psicóloga, graduada pela Universidade Federal de Alagoas (UFAL), Unidade Palmeira dos Índios; especialista em Psicologia Clínica. E-mail: psi.amandaasantos@gmail.com.

[3] Doutor em Psicologia, docente do curso de Psicologia do campus Arapiraca e do Programa de Pós-graduação em Psicologia da Universidade Federal de Alagoas (UFAL).

"C'EST UN MÉLANGE DE PEUR ET DE COLÈRE": EXPÉRIENCES DE VIOLENCE OBSTÉTRICALE DANS LA CAMPAGNE D'ALAGOAS

RÉSUMÉ

Cet article cherchait à comprendre les nuances de la violence obstétricale sur la base des rapports quotidiens des femmes des zones rurales d'Alagoas. Cela part d'une compréhension intersectionnelle de ce phénomène, en le reconnaissant comme étant multiforme et d'expression diversifiée. Sur le plan méthodologique, des cercles de conversation virtuels ont été utilisés avec un groupe de femmes et, à des fins d'analyse, les hypothèses de l'outil analytique d'intersectionnalité ont été utilisées combinées à des aspects d'analyse de contenu. Comme résultats, les expériences vécues par les femmes sont mises en valeur, ce qui indique le manque de connaissances sur le sujet, les formes micro et macropolitiques de l'exercice du pouvoir violent et ses répercussions psychosociales pour les victimes. A partir de là, nous plaidons pour l'élargissement des débats sur les violences obstétricales à la lumière des aspects intersectionnels qui la caractérisent. Il faut également élargir les possibilités d'écoute des victimes de violence et de reconnaissance de leurs innombrables violations, en cherchant à promouvoir l'autonomisation de leurs histoires.

MOTS-CLÉS

Violence obstétricale ; Intersectionnalité ; Femmes.

"ES UNA MEZCLA DE MIEDO Y RABIA": EXPERIENCIAS DE VIOLENCIA OBSTÉTRICA EN EL INTERIOR DE ALAGOAS

RESUMEN

El presente artículo buscó conocer matices de la violencia obstétrica a partir de relatos cotidianos de mujeres del agreste alagoano. Parte de una comprensión interseccional sobre este fenómeno, reconociéndolo como multifacético y de expresión diversa. Metodológicamente, se recurrió a grupos de conversación virtuales con un grupo de mujeres y, para efectos de análisis, se utilizaron supuestos de la herramienta analítica de la interseccionalidad combinados con aspectos del análisis de contenido. Como resultados, se señalan las experiencias vividas por las mujeres, las cuales indican el desconocimiento con respecto al tema, las formas micro y macropolíticas de ejercicio de poder violento y sus repercusiones psicosociales para las víctimas. A partir de esto, abogamos por la ampliación de los debates sobre la violencia obstétrica a la luz de los aspectos interseccionales que la caracterizan. También, la necesidad de ampliar las posibilidades de escucha de las víctimas de violencias y el reconocimiento de sus numerosas violaciones, en busca de promover el empoderamiento de sus historias.

PALABRAS CLAVE

Violencia Obstétrica; Interseccionalidad; Mujeres.

INTRODUCTION

This text takes as its starting point the particular contexts of maternity and postpartum of women from the interior of Alagoas, seeking to understand, from singular experiences, instances of obstetric violence routinely committed against themselves or against others in their surroundings. Although in this research the narration of these experiences of gestation, childbirth, and postpartum refers to women, it is important to already highlight the diversity of gestational experiences, recognizing that these experiences are not limited to cisgender women. In this sense, we understand that trans men and non-binary people with a uterus can also share these experiences.

As an argument, it starts from the personal experiences of two of the authors, women for whom it is daily frequent to hear accounts of obstetric violence committed against women in their own family circle, with a relative lack of knowledge among the victims regarding this category of violence and even the normalization of disrespectful practices reproduced by health professionals.

In the same way, it is also important to initially situate the understanding that we start from to know accounts and understand experiences of violence. Here, we recognize that violent forms of social interaction make up a multifaceted phenomenon. We also acknowledge that, in the Brazilian context of numerous inequalities and vulnerabilities, this has become a social issue due to its diverse expression. These many possibilities for the production of violence in society cause damage in multiple spheres of our lives, such as physical, psychological, social, moral, among others. In light of this, violence is not characterized as a rigid social marker; it is formed by various layers and includes a broad typology, one of which is obstetric violence (Silva; Serra, 2017).

OBSTETRIC VIOLENCE AND ITS PSYCHOSOCIAL REPERCUSSIONS

In general, it is possible to say that obstetric violence is characterized by dehumanized attitudes, procedures, medications, and non-consented techniques, as well as the absence or distortion of information by any health service professionals. Among the practices that characterize it are included actions or omissions directed towards women throughout the prenatal period, during labor or postpartum, unnecessarily causing pain, any kind of harm or suffering. This, moreover, without explicit consent or in disrespect of the woman's autonomy (Katz *et al.*, 2020).

According to Santiago (2019), the term has three interrelated aspects: gender rights, the right to health, and human rights. Regarding gender rights, this first aspect is expressed through the power relations that permeate and organize the social field itself, the

institutions, symbols, laws, doctrines, and policies. As Gomes and colleagues (2018) point out, all of this is interconnected by gender issues that promote the reproduction of violence, both in the symbolic and material fields. Thus, the disrespect for gender rights and obstetric violence manifest through inequalities and discriminations, in which the category of existence that is predominantly affected is women simply for being women (Gomes *et al.,* 2018).

Regarding the second aspect, in general, human rights ensure that all people are treated with respect, dignity, and equality, which includes the right to receive adequate health care free from violence, as Oliveira and Albuquerque (2018) clearly point out. These authors highlight that situations of obstetric violation disrespect intrinsic rights of human beings, both for women and their children, such as: the right to life, the right not to be subjected to torture and cruel or degrading treatment, the right to information, the right not to be discriminated against, and the right to health. In the case of the latter, according to Oliveira and Albuquerque (2018), this form of violence undermines access to qualified and humane health care, potentially resulting in lasting physical and psychological harm, affecting the health and well-being of the mother-baby duo.

Moreover, it is important to highlight that this violence occurs through the appropriation or domination of women's bodies and reproductive processes, using a series of mechanisms or technologies, such as the abuse of medicalization, the pathologization of natural processes, and hostile treatment. In this sense, the abuses committed by health professionals can be exemplified in the form of negligence in care, verbal violence, physical violence, and sexual violence, in addition to psychological and institutional violence (Silva; Serra, 2017). In other words, obstetric violence exists in various forms, whether they are physical, psychological, or sexual, constituting any act that causes negligence, disrespect, and mistreatment (Zanardo *et al.,* 2017).

As pointed out by Mendes (2016), it is possible to perceive the breadth of the concept, which can be applied from the misconducts caused by the healthcare team to the violence committed by the State when it does not provide adequate public policies and subsidies for the assistance to women to occur fully. It can also encompass aspects such as the structural failures of hospitals, clinics, and the healthcare system in general. Likewise, it is essential to understand that the term is not restricted only to the work of doctors, but to all professional categories in health that reproduce examples of violations of women's rights.

Despite this, however, the term still faces criticism, as some professionals backed by medical councils and societies declare that its use would be a violence against obstetricians (Katz *et al.*, 2020). For these authors, a possible outcome may be the fact that while in countries like Argentina and Mexico, perpetrators of obstetric violence are subject to criminal accountability, in Brazil, on the other hand, there is no current federal legislation

aimed at addressing the aspects concerning these violations. In light of this, it is evident that obstetric violence is a complex and multifaceted issue that involves not only legislation but also culture, education, and the awareness of health professionals and society at large.

In any case, the use of the term to characterize certain behaviors in different scenarios allows, according to Katz *et al.* (2020), for the understanding of these violations as gender-based violence, in order to ensure appropriate interventions to prevent this type of abuse. In line with this, Sens and Stamm (2019) state that the various types of violence can be characterized as the transformation that occurs from difference into inequality in a hierarchical power relationship, supporting that the other (in this case, a woman) is perceived and treated as an object of action. That is, the occurrence of obstetric violence takes place due to an eminent drive for appropriation of both the body and the sexual and reproductive processes of women by the multi-professionals who make up the health sectors.

It is important to highlight that many women are subjected to this without even having the knowledge that such behaviors amount to violence (Zanardo, 2017). In this regard, Dias and Pacheco (2020) report a difficulty regarding women's responses immediately following the violence suffered, as the process of reacting to violations involves overcoming barriers, often without resources and assistance for that. This reinforces the passive position of violently abused women in a state of helplessness. Furthermore, these authors emphasize that the predominance of culturally constructed medical knowledge corroborates hierarchical practices, without the consent of women, which results in the invisibility of violence and little encouragement to report it.

Furthermore, the cultural construction of the medical figure as the "holder of knowledge" and the lack of information about this type of violence contribute to the increasing barrier between doctor and patient, leading to a certain fear of asking and questioning the procedures to which they are subjected, accepting situations that cause discomfort and unease without complaining (Diniz, 2006 *apud* Silva; Serra, 2017).

As effects, these practices lead to the loss of the patient's autonomy, limiting the ability to make decisions about her body and sexuality during the processes of gestation, childbirth, and postpartum (Oliveira; Albuquerque, 2018). In this regard, the authors continue to emphasize that obstetric violence, by resulting in the loss of women's autonomy, directly interferes with their capacity to make decisions regarding the physiological and psychological aspects that comprise their pregnancy and postpartum cycle. Thus, the normalization of disrespectful speech and the reproduction of behaviors that oppress and neglect the specificities of women silence their pain and choices, which contributes to a negative experience.

With a similar understanding, Pereira *et al.* (2016) state that obstetric violence exposes women to situations of disrespect, mistreatment, and violation of their rights,

bringing psychological and physical consequences both for the mother and for the newborn, considering that it is a moment of greater vulnerability, where there is a restriction of their autonomy, women may suffer psychological damage and develop possible psychiatric disorders.

This is also in accordance with what was stated by Pasche, Vilela, and Martins (2010). The authors emphasize that childbirth is seen by women as a moment of apprehension and a threat to life, considering the loss of their protagonism and submission to sometimes violent technologies. Thus, the experience of childbirth becomes negative and painful, which can interfere with their family planning and the decision to have more children.

Finally, it is also important to point out that, according to the World Health Organization (2014), all women are entitled to the standard right to the highest attainable quality of health, receiving respectful and dignified assistance during the pregnancy-puerperium cycle, as well as having the right to non-violence and non-discrimination. Although it may seem like a basic premise in caring for parturients, as evidenced by the discussion here, there is evidence that disrespectful and violent practices are commonly present in the daily life of institutions that provide obstetric care at various levels of assistance. This fact demonstrates the need for us to know and denounce how these serious violations and obstructions of the exercise of reproductive rights are articulated and perpetuated, along with the various psychosocial disadvantages that result from them.

ABOUT POWERS AND DOMINATION: INTERSECTIONALITIES OF OBSTETRIC VIOLENCE

To understand how obstetric violence is experienced daily by women, it is essential to comprehend how the relationship between violence and social domination is established, since these two phenomena have very well-defined functions in society. In a simplified manner, we will attempt to demonstrate that the different forms of domination feed off the power of imposing violence to promote their hegemony, so that their propagation occurs through various fronts: Physical, moral, symbolic, sexual, and psychological.

As a starting point, it is important to remember that there is already a consolidated discussion in the human sciences regarding the relationship that encompasses different social markers of difference, such as issues of race, class, gender, ableism, regionality, and others. Here, encompassed by the proposition of intersectionality as a theoretical-analytical tool, we understand that different systems of oppression and inequality interconnect and overlap in people's lives (Collins; Bilge, 2021; Crenshaw, 2002). For her, it becomes essential to understand that women are not a homogeneous group. They have diverse identities and experiences that are determined by race, social class, sexual orientation, age, and other aspects of their identity. The intersectional analytical perspective recognizes the

interconnectedness of these different forms of oppression and perceives how they overlap and intersect (Collins; Bilge, 2021). Therefore, intersectionality guides a conception of identity based on a situated experience, requiring us to move beyond the "particular boxes that hinder struggles globally and serve the heterogeneous guidelines of the West" (Akotirene, 2019, p. 29).

In the context of health, such a proposition can guide the formulation of more effective interventions among different individuals. It also emphasizes that gender oppression is interconnected with race, social class, and other categories, and that these intersections shape life experiences and opportunities in very particular ways. For example, it makes us acknowledge that black and Indigenous women are more likely to suffer obstetric violence than white women, or justifying abusive practices against black women by the distorted idea that they are naturally more resilient to pain (Lima, 2016). This happens because they face racial and ethnic discrimination in the healthcare system.

As Assis (2018) highlights, racial bias is rooted in Brazil's socio-historical context, taking shape in the constitution of both the subjects and the environments to which these subjects belong. The consequences of a history of enslavement in the country result in changes across different dimensions of daily life, such that there is a perpetuation of the notion that non-white people are "devoid of intelligence, humanity, political articulation capacity, not being considered as targets of full citizenship" (p. 548). The author also emphasizes that these remnants of coloniality foster a tangle of ideologies in popular imagination that associate inferiority and objectification with non-white populations, naturalizing the subalternity and vulnerabilities of these individuals.

In the same way, low-income women are more likely to suffer obstetric violence than middle- and upper-class women. According to Fagundes *et al.* (2022), social class is a factor that contributes to a greater exposure of women to obstetric violence, as it is intrinsically correlated with the pregnancy profile, revealing factors such as educational level and the type of access to the healthcare system, whether public or private, as conditions that make women more vulnerable, making them more likely to suffer violations. In this sense, the socioeconomic circumstances of birthing women affect their access to quality services and the treatment offered to them (Diniz *et al.*, 2015).

In this regard, intersectional discriminations establish hierarchies that place women at a greater disadvantage in accessing health care (Biroli; Miguel, 2015). Or, to be even more specific, "in Brazil, skin color/race, ethnicity, social class, and gender are determinants in how the population lives, falls ill, and dies" (Lima, 2016, p. 8). In other words, as an effect of the interweaving of different dominations, the greater the vulnerability, the more negligence tends to occur. Non-white, poor women, drug users, adolescents, and those without companions are more likely to experience negligence and omission of assistance, which can

result in significant harm to their health (Diniz *et al.*, 2015). We would also add to this relationship other aspects such as being a resident of peripheral or rural areas and being or not being a person with a disability.

Conduct in the obstetric context contributes to the reproduction of these hierarchies, in such a way that institutions naturalize and perpetuate inequalities in access to health, reinforcing oppressions and the hierarchization of the aforementioned markers (Lima *et al.*, 2021). As a consequence, social relations are internalized that contribute to the exposure of black and poor women, in particular. The marginalization of the birthing woman based on differences in gender, social class, and ethnicity subjects her to interventions and manipulations, often without her consent, exposing her to unnecessary suffering which can lead to drastic and irreparable consequences (Aguiar, 2010).

In this perspective, according to Lima (2016), many women suffer mistreatment during childbirth and face social difficulties in accessing services and receiving good care. The lack of knowledge about violence and the childbirth process leads many women to believe that excessive interventions and medicalization during childbirth are considered normal or of quality care, favoring the normalization of violence. Thus, for the author, obstetric violence is "[...] not a consequence of a biomedical, mechanistic, and hegemonic model, but rather constitutive of it" (Lima, 2016, p. 19).

Furthermore, in a study conducted in a public maternity ward in Salvador, McCallum and Reis (2006) found from the statements of the parturients that the experience of childbirth is marked by a sense of fear, whether of pain, of death, or of being mistreated by healthcare professionals. Under similar conditions, Domingues *et al.* (2004) in their work points out that the complaints of the parturients were inclined towards the lack of information provided during the assistance, which causes the pregnant woman to feel detached from the process taking place in her own body, in addition to experiencing a professional conduct that is rude, impatient, disrespectful, prejudiced, and moralistic.

Aguiar (2010) emphasizes that during childbirth, what predominates are interventions and technical procedures, where sometimes the doctor performs the service and leaves, without interacting or clarifying about the procedures carried out. In this context, "the knowledge of health professionals, especially doctors, is determinant. What women feel and know about their own bodies tends to be disregarded" (Mccallum; Reis, 2006, p. 1488). In this way, the woman is objectified, having her complaints and words invalidated, being subjected to purely technical interventions that are not humanized. In light of this, there is a normalization of motherhood as a social role of women, which also brings the normalization of the pain of childbirth as a punishment for the supposed pleasure during sexual intercourse and as something that a woman is capable of enduring (Aguiar, 2010).

An intersectional intelligibility grid also makes us see that processes like giving birth and being born are not merely physiological, but sociocultural phenomena, often permeated by emotional ambivalences. In this sense, the practices of health professionals reproduce the microcosm in which individuals become subjects. If, socially, there is a tendency to naturalize and even deny the existence and effects of practices of social domination, one could assume that it would be no different in the context of health practices. In this regard, as noted by Sans and Stamm (2019), such practices are usually not interpreted by professionals as violent, but as an exercise of authority in a context considered complex. Thus, violences are reproduced daily and become established as routine procedures of services.

Ultimately, an intersectional approach to this issue primarily involves recognizing that the health-illness process, whether for pregnant individuals or not, has among its determinants the maintenance of the subalternization processes to which a significant part of our population has been subjected (Pereira, 2018). Alongside this, it also requires understanding that the solutions must take into account the specific experiences and needs of different groups of women. This implies ensuring that health policies and maternity care systems are sensitive to issues of race, class, sexual orientation, and other forms of oppression. It must be understood that the fight against obstetric violence is a fight for human rights. As a strategy to confront these violations, the perspective of humanization in health emerges as a strategy to discuss gender violence and other rights violations committed in health institutions against users. It also requires a collective effort to promote a culture of respect, consent, autonomy, and control over maternal health care that empowers women and professionals with information and education about rights and options during pregnancy and childbirth (Aguiar, 2010).

METHODOLOGICAL ASPECTS

The study started from a qualitative research approach (Minayo, 2007), methodologically employing online questionnaires and virtual discussion circles with a group of women (Sampaio *et al.*, 2014). Regarding the questionnaires, they were used for an initial survey of potential interested participants, answering questions about personal or other experiences of obstetric violence; whether they were interested in participating in the virtual meetings, and also having initial access to information about the development of the research. The established inclusion criteria were: Female gender, age over 18 years, whether or not experiencing motherhood, completion of the form, and acceptance of voluntary participation in the second stage of the research. Thirty-one women answered the questions.

Regarding the discussion circles, they were held virtually via the Meet platform, in two meetings with the participation of five women. The first meeting was intended for the

presentation of both the research and the participants and researchers, allowing access to the interviewees' narratives of their experiences with obstetric violence. In this phase, a semi-structured question guide was also used. The second discussion circle aimed to expand on the discussions previously outlined and to provide guidance concerning women's rights in the aforementioned context.

The group discussions were recorded and later transcribed. From them, intersectionality was used as a starting analytical tool, recognizing that experiences are shaped by a complex intersection of social markers such as gender, race, social class, among others (Collins; Bilge, 2021). Additionally, data triangulation was adopted for the interpretation of the content through the production of thematic categories (Santos *et al.*, 2020).

Regarding the ethical aspects, this study adhered to the guidelines and criteria established in Resolutions 466/12 and 510/16 of the National Health Council (*Conselho Nacional de Saúde* - CNS), having been submitted and approved by the Research Ethics Committee of the Federal University of Alagoas (*Comitê de Ética em Pesquisa da Universidade Federal de Alagoas*) (CAAE nº: 69858023.1.0000.5013, Parecer nº: 6.191.988).

CHARACTERIZATION OF THE PARTICIPANTS

We consider it relevant to briefly present where the accounts originate, who these women are, from what place they speak, and how obstetric violence encountered them. The names used are fictitious and the descriptions safeguard the necessary information.

Íris

Woman, 27 years old, mixed race, married, however when she experienced moments of obstetric violence she was in the process of getting a divorce, holds a degree in Psychology, mother of two children. Her experiences during the pregnancy and postpartum cycle were quite distinct, especially regarding violence. In her first pregnancy, in 2015 at 18 years old, she went through a series of mistreatments that started from prenatal care and lasted until the late postpartum period, when the violence inflicted on her and her baby had long-lasting effects. She did not imagine herself getting pregnant again, and when it happened at 24, she panicked; her reactions were of denial and fear of that scenario repeating itself. It was from that moment that she began researching obstetric violence, realizing that she had been yet another victim. There was a pilgrimage to find an obstetrician who would make her feel safe and respect her voice. Despite having to undergo another cesarean section, she reports that she was able to redefine the traumas of her first delivery through the humanized care to which she had access during this second birth.

Melissa

Woman, 57 years old, white, single in civil status, but separated for many years from the father of her daughters. She studied elementary school as a teenager, and later as an adult, completed high school through Youth and Adult Education (*Educação de Jovens e Adultos* - EJA). Her profession has always been a farmer, and she lived most of her life in rural areas. Throughout her life, she also worked as a seamstress. She is currently a mother of four daughters, and her experience with obstetric violence was very significant during her first pregnancy at 16 years old. When she gave birth to her first daughter, who is now 41 years old, it was a very painful episode, as she was young and had no experience with the context of childbirth; she didn't know what procedures and behaviors were normal and couldn't distinguish episodes of violence. In addition to being a victim of obstetric violence in various forms, she witnessed neglect and disrespect happening to other women around her, which intensified her suffering even more.

Flora

Woman, 46 years old, mixed race, married, with a completed higher education in Pedagogy, mother of three children. All her births were through surgery due to clinical issues. Her first birth went smoothly, with good care throughout the process. During her second pregnancy, things were different; she underwent emergency surgery, and after much insistence, she was allowed to notify her husband at the hospital entrance that she was going to the operating room and was left alone during this process. Her third birth was also marked by violence, unfortunately, even more intense. It was a scheduled birth with the intention of tubal ligation, with a doctor already known in the city who had attended other pregnant women in her family. He provided violent, negligent, and disrespectful care, resulting in repercussions from medical errors both in the immediate postpartum, requiring surgical intervention, and over time with psychological consequences.

Jasmin

34 years old, married, black, mother of two children, with a completed higher education in Agronomy and Pedagogy. Her experience during her children's prenatal care was positive, the team was attentive and helpful. However, no information about the birth plan was provided, nor was obstetric violence discussed. All of her deliveries were through surgery; during the birth of her first child, at the beginning of 2020, she was accompanied by her husband. During the delivery, the medical team did not provide her with guidance or establish any dialogue. In addition, the Kristeller maneuver was performed, and even though

she was aware that it was not correct, she could not react at that moment because she was terrified. In her second pregnancy, in 2021, her husband was not allowed to enter the room, which caused distress as she was alone during a vulnerable moment. In all the procedures, Jasmin, although she did not know how to identify the types of violence she was subjected to, recognized that they were violations; however, she felt weakened and could not react to the situations.

Magnólia

22 years old, single, mixed race, mother of three children, completed high school. She has worked as a receptionist and kitchen assistant and is currently unemployed. All her births were by surgery due to clinical issues, and her first pregnancy occurred when she was 18 years old. The prenatal care was smooth, and she was informed about the birth plan and its importance for the birthing person. However, there was no discussion or guidance regarding obstetric violence. At 40 weeks of pregnancy, she went to the hospital, where several examinations were conducted, and she was sent to the surgical center only after the professionals had difficulty hearing the baby's heartbeat. At that moment, the companion was not allowed to enter. During the delivery, the Kristeller maneuver was performed. In her third pregnancy, in 2022, the team treated her harshly, in addition to making comments about her age and the number of children, causing embarrassment. Magnólia only became aware of the violations she suffered recently, months after the birth of her third daughter, because the notion of violence was linked only to physical issues.

IGNORANCE AND PERPETUATION: SOME EVERYDAY AND COMMON ACCOUNTS OF VIOLATIONS

In general, it was noted that the knowledge about the subject, while common to all, had significant limitations. Among the women who took part in the circle, it was found that the information about the subject was accessed only after they became mothers and, consequently, were exposed to violence. Thus, it is essential to recognize that it was the concrete experience of violence that brought them closer to the concept, even as a process of later elaboration. This is evidenced by reports such as:

> And in the delivery room, they would say so many ugly things, with ugly jokes, right? And they would be laughing, cracking jokes. I never thought I would go through such mockery. And to this day, it hasn't left my mind. [...] I didn’t know. For me, it was normal, right? Those swear words, right? I understood that it was normal, that it had to be that way, you have to endure it, right? The pain and the words... those ugly words the nurses would say to the person. For me, it was normal, right? Later, I said, “I wonder if it’s really like that, the nurse keeps saying horrible things to the person?” (Excerpt from an interview, Melissa).

> It's just that I only became aware of the violence a long time later, when I became pregnant with my second daughter, surprisingly, right? It took me a while to make this connection, right? (Excerpt from an interview, Íris).

> He said that I was in pain because the doctor had jumped on my belly for the baby to come out. So, I had no idea that this was obstetric violence. I came to know about obstetric violence after a certain time. I think it was more or less this year that I got some understanding (Excerpt from an interview, Magnólia).

This helps to limit the effects of obstetric violence on other dimensions of women's lives. As the categories/types that make it up are poorly understood elements, the risk of exposure to situations of disrespect, mistreatment, and violation of their rights increases, as do the psychological and physical consequences, as pointed out by Pereira *et al*. (2016).

During the discussion circles, it was identified that often micro-violences go unnoticed or are considered normal. In other words, besides shaping the dynamics of care, they are present in the daily life of the health network in such a symbiotic way that their normalization composes the structure of an authoritarian and violent system. According to Diniz (2006 *apud* Silva; Serra, 2017), the lack of information combined with this cultural construction of medical knowledge contributes to the hierarchical maintenance between the doctor-patient dyad, resulting in a certain fear of questioning certain procedures, even in situations that cause discomfort. Similarly, Dias and Pacheco (2020) point out the difficulty women have in responding to the violations they suffer, as this process involves overcoming barriers, often without resources, guidance, or assistance, as we can see in the following statement.

> Almost all women have experienced obstetric violence, so sometimes they don't know how to deal with it. Not because they don't know much about the violence, right? But because they really don't have access. Sometimes there is no choice, right? And you have no way to express it, so it becomes more difficult (Excerpt from an interview, Íris).

From an intersectional analysis perspective, far from indicating that such issues are strictly individual aspects, it is essential to point out that this lack of knowledge affects relationships of discrimination based on gender, race, social class, regionality, place of residence, among others. As reported by one of the participants, "the more rural, the more Northeast, the less social condition you have, the worse it gets." In other words, the greater the vulnerability, the more neglect tends to be committed. This also appears in the following excerpts:

> When we were about to go in, they got confused and thought we were from the private sector, and I was already crying a lot, and I was on the first floor, right? Then the lady said: Why are you crying? I said no, it's because my husband won't be able to go in, I'm very nervous, after all, it's a major surgery, right? [...] Then the lady said: Oh no, don't worry, he will go in or something like that, [...] then later the lady took my file and realized that it was from SUS. She said: Oh, you're not from here, you're from SUS, so when I arrived at SUS, my husband couldn't go in. He didn't watch the delivery, I was alone during the delivery [...] I also think that these issues happen because it's a woman who goes through it, you know, maybe if it were a man there would be way

> fewer reports, because it seems that women are more, are always more vulnerable to any type of violence. Obstetric violence seems to be just another one of them. Everything is allowed when you are a woman, right? Because if you are pregnant you experience obstetric violence, if you wear a short outfit, you are harassed. If you know... it seems that everywhere you go, the first criterion is being a woman, so maybe she is not that deserving of respect (Excerpt from an interview, Jasmin).

The narratives demonstrate that behaviors in the obstetric context, stemming from the maintenance of discriminatory systems, expose women to disrespectful situations, violations, and mistreatment. They permeate access to healthcare, directing women to where it is convenient for them. As pointed out by Gomes *et al.* (2018), due to being a complex phenomenon and having its reproduction perpetuated through unreflective behaviors, this provides leeway for male domination to act in society as an organizing element and impose the idea of female inferiority, blaming the victim. Alternatively, such behaviors can become normalized, understood not as violent actions but as routine procedures in the service. Additionally, these actions lack authority when exercised, considering the complexity of assistance.

Thus, it is not possible to think of obstetric violence disconnected from the assumptions of the medicalization of bodies, especially of the feminine. The knowledge and perceptions of women about their own bodies are often underestimated. As Aguiar (2010) points out, women are treated as objects, with their concerns and words disregarded, subjecting themselves to hostile and violent treatments. The shocking account of one of the participants shows this:

> I went back to the hospital, to the same hospital I had been to feeling very unwell, right? Then once again I was evaluated with another internal examination, by another professional who also didn't explain to me what was going to be done, so it was the second one in a short period. And during this labor, a team of interns from a technical course came to me. And I simply received several more internal examinations. Several. I can't mention the exact number, but it was no less than fifteen. So that was another issue that left me very shaken, right? It felt like I was a sample, right? As if people were going to conduct experiments.
> It was when another doctor arrived, this other doctor, once again asked me to lie down, performed another examination. He said that everything was fine, that it was progressing and that it was normal. And I asked him if it was normal to be like this, you know, purple, with the lips purple, everything purple, I had a lot of pressure on my neck. He said it was all normal, that this was just the concern of a first-time mother and he started to really invalidate my doubts, as if only his voice as a doctor was the voice that should be heard, you know?
> [...] And then he told me that he was going to give me a medication and that this medication would help me with the delivery. It was then that they applied oxytocin to me in the IV. I didn't have any knowledge because it wasn't explained once again what it was. And then automatically, as soon as the dosage was given, I started to feel even more respiratory discomfort and I informed them that I was having trouble breathing. I tried to take a breath, but the air wasn't coming. And I started to get very nervous. They said, 'Look, I don't have time for this, now you have to push because the baby is going to be born' and that's when my water broke, but when it broke it wasn't normal, it was with completely greenish amniotic fluid, which indicated that the baby had already had meconium. And I was very nervous, I didn’t know what it was, what was happening. It's just that one of the nurses in the room saw and asked me to quickly go to the delivery room, immediately, because the baby had to be born and I could hardly

> walk. That's the word, I could hardly walk from the pain I was feeling. Not to mention that I wasn't able to breathe. And they, frankly, were pushing me to the delivery room (Excerpt from an interview, Íris).

It is still important to highlight the way in which such violence is perpetuated over time. Under different guises, it has affected and continues to affect women of different ages, adapting and presenting itself in various ways throughout generations. The five participants, separated by more than three decades in age, illustrate similar situations of abuse and disrespect during the pregnancy and postpartum process. This seems indicative that this perpetuation is indicative of how the subjugation of women's bodies and their sexual and reproductive processes persists. It is understood that the violations committed in the past and currently form a common experience that, although sometimes separated by chronological time, composes the same entanglement.

This impacts, including, the people directed to care for these women during their processes of pregnancy, childbirth, and postpartum. Notably: Other women! A large part of them are also victims of obstetric violence at some point in their lives. Therefore, they are also submerged in the system of appropriation of the female body by the assistance teams.

PSYCHOLOGICAL AND EMOTIONAL REPERCUSSIONS OF OBSTETRIC VIOLENCE

Speaking about the repercussions of obstetric violence implies understanding its devastating nature. It involves recognizing that this violence is a reality that affects the lives of many women. It entails making visible the experiences of these women, which are often silenced or delegitimized. It involves acknowledging that obstetric violence is a violation of human rights, health, and gender. During the discussion circles, it was possible to perceive the numerous repercussions that violence has caused in the lives of these women, which also have consequences for their children. It is a cruel way to demonstrate how women are targets of violations, how in moments of vulnerability they are subjected to horrific situations that put their lives at risk. Lack of consent, absence of empathetic communication, and inadequate pain management are prominent aspects of the narratives and expose a series of inhumane and disrespectful practices that often occur during childbirth. Furthermore, episodes of restricted mobility and lack of attention have also been reported.

As consequences, there are damages to emotional well-being, with feelings of helplessness, anguish, and disrespect. Diniz *et al.* (2015) indicate that there are extreme consequences of this category of violence, which can include degrading and inhumane childbirths, health complications, severe psychological trauma, and in some cases, death due to negligence.

She turns a moment that should be one of care into a traumatizing experience. Some distressing reports highlight a series of issues related to medical assistance and

women's health in the context of childbirth and the postpartum period, emphasizing the dangers of medical neglect and the need for ongoing reform in the healthcare system aimed at ethical and comprehensive care.

> Then I went through a terrible process of medical error. He did the cesarean section and didn't close the cut as it should, it didn't cauterize as it should, I had bleeding on the walls of the abdomen and it almost killed me. I already went home with some bruises on my abdomen, but I just didn't know anything, right? And then the days went by at my house and I lost weight and turned pale, right? A very big fatigue, and I didn't know why, I just knew that I wasn't well. So, I was in my house with my baby in the room, when I got up my belly started bleeding and I started to look and that black blood came out, dirtying the whole house. And then I started to panic, and the way I was in my nightgown, I went to the hospital with my husband. [...] The on-call doctor looked at me, there I was, terrified, not knowing what was happening, looked at me and said: 'Did he puncture her bladder?'. Then I thought, oh my God, I'm not going to make it, I'm going to die, I'm going to die. I'm not going to see my children grow up (Excerpt from an interview, Flora).

These accounts highlight that the repercussions of obstetric violence leave lasting marks and interfere with both the psychological health of the mother and the physical health of the child. Oliveira and Albuquerque (2018) emphasize that there may be a compromise to physical integrity, even putting the lives of those involved in the situation at risk. It also triggers consequences in the realm of women's sexual and reproductive choices, impacting the decision to have more children, since its effects are not limited to the immediate moments of the event but reverberate over time. Traumatic experiences during childbirth can generate great fear and anxiety regarding future pregnancies. Women who have been victims of obstetric violence may hesitate to conceive again due to the fear of reliving the abuses previously suffered (Pasche; Vilela; Martins, 2010). Such a situation was also found during the meetings with the interviewees, as indicated by the following excerpts:

> So, after that, after this happened, I was very afraid of having another child. Until some time ago, if someone asked me anything about giving birth, about children, I would panic, I couldn't talk about it, because the pieces started to fall into place and I looked, I looked for a year and a half at the results of that obstetric violence, in his head, my son's (Excerpt from an interview, Íris).
>
> And it's something like that, which made me give up on a normal birth, I don't even know why I never thought about a baby coming out from there, God forbid. But what made me terrified was that, being poked by everyone, without explaining your life, you know? [...] And there's that cut, right? They make in the vagina for the baby to be born and that everyone knows it's not recommended, but they keep doing it. So these things that I, that my sister-in-law had also had a baby 4 months before me, right? And she went through that with a normal birth and I didn't want that for myself (Excerpt from an interview, Jasmin).

Through the reports, and in accordance with McCallum and Reis (2006), it is noted that childbirths, especially for women who have been violated, can be marked by feelings of apprehension, whether due to fear of death or fear of being subjected to interventions without their consent and in a dehumanizing manner. Thus, the negative and painful experiences present in the narratives demonstrate that exposure to unnecessary

interventions and suffering results in significant harm to their sexual and reproductive health and family planning.

Furthermore, abusive, disrespectful, and/or unnecessary practices in the care provided to women affect their well-being, causing impacts on their mental health. This is because being subjected to humiliating situations inherent in violence, women face not only physical traumas but also violations of their autonomy and dignity. Pereira *et al.* (2016) discuss that these violences affect women's agency during their childbirth process, resulting in psychological suffering and possible psychiatric conditions, which can be evidenced in the stories of the interviewed women.

> I have, I'm treating myself, I'm undergoing treatment for panic syndrome and I had a crisis during childbirth, I couldn't do anything, there was no one with me there, you know, the only thing I could do was cry, I couldn't even move because I was anesthetized. [...] I developed panic syndrome, I'm taking medication, I'm in therapy (Excerpt from an interview, Jasmin).

> I ended up like this, I really got sick, psychologically speaking, I got sick because of this whole process of neglect, right? (Excerpt from an interview, Flora).

> I have no way to go through a process like this unscathed. No matter how much we may not have perception or awareness at that moment, there are later consequences (Excerpt from an interview, Íris).

> It's been a long time, but when I remember it feels like it was yesterday. So much so that I said I was 47 years old, right? It was really horrible (Excerpt from an interview, Melissa).

Considering the perspectives brought by women, it can be noted that the negative psychological repercussions are very present in their experiences. The narratives point to a feeling of widespread mental illness, to the extent that this marker is present in most of the accounts and is independent of when the violence occurred. This highlights a very discussed issue throughout this work: the multiple facets of obstetric violence. In its psychological violence aspect, what the reports indicate is how the damage can be as intense as any other form, even because women often have to deal with mental and psychological issues alone, as they are routinely made invisible by society.

In addition to this, there is the feeling of fear frequently mentioned in their experiences. It is so present in this context because, in the popular imagination, as highlighted by Aguiar (2020), childbirth is certainly a dangerous event that puts both the woman and her child at risk. In this sense, in theory, being under hospital care should provide more security to the parturients. What practice demonstrates, however, is poor assistance, which exacerbates the risks of complications and fatalities for the mother-baby dyad and makes fear take on the contours of mental illness. This situation was expressed in the moment of helplessness reported by Flora, with a statement that gives title to this work:

> A horrible, horrible experience. And you are there, what can you do at that moment? You feel extremely weakened, vulnerable, you feel scared, right? The prevailing thing

> there, what prevails is the feeling of fear, right? You are there in the hands of strangers or acquaintances, so to speak, right? But that's how it is, in a situation like that, we don't know how to defend ourselves. It was a horrible feeling that at that moment I was stuck, I was impacted and suffered the consequences [...] it's a little painful to remember, it's a mix of fear and anger, for being vulnerable and at that moment not being able to defend oneself (Excerpt from an interview, Flora).

This analytical category about the repercussions of obstetric violence supports a range of discussions, including the fact that recalling experiences during the meetings helped these women to rework their experiences. Based on the conception that obstetric violence has effects throughout life, materializing one's own experiences and those of others is like co-creating a narrative filled with sensitivity. Acting and thinking this way implies, even if unintentionally, politicizing the experience, opening doors to new possibilities of life even amidst violence (Santiago, 2019). In this way, one has the perception of the participants regarding the meetings and the sharing of narratives:

> I think that when we start to become aware, we are not only able to reframe our experiences but also take on a responsibility to share information. [...] I was able to reframe the birth of my daughter compared to the birth of my son, which was completely different; it was a calm, respectful birth where I was able to hold her in my arms after she was born. Everything was different, but not less painful because I ended up reliving everything again, due to the lack of information, the lack of knowledge, even though I was more prepared. [...] So that was my birthing experience, with obstetric violence, with infinite violations (Excerpt from an interview, Íris).

> I thought it was good, I thought it was wonderful to participate in this meeting. I learned about rights that I didn't know existed. And now to understand that a pregnant woman arriving at a hospital must be well received by that team and treated well, especially since she comes, let's say, with a sense of shame, right? She will have her body exposed and still hear ugly curses and more things. It was very good to participate. It was great, I liked it a lot. What I have to say is that women should not stay silent anymore, they should speak out (Excerpt from an interview, Melissa).

> Thinking about obstetric violence is thinking about one of the most cowardly forms of violence against women. It's about taking a moment of extreme vulnerability; I could even use the word attack, you know? Because in some situations, you are really attacked and you can't even defend yourself because you are in a state of total vulnerability (Excerpt from an interview, Flora).

> I like to talk about my pains, they lessen when I talk, I enjoy discussing them. [...] I believe the experience was very beneficial, I think that talking about problems is the starting point for solving any problem and it was really nice (Excerpt from an interview, Jasmin).

> I loved talking to you, I loved gaining more knowledge about the subject, you explained several things I wasn't aware of. What I can do is share with other people I know who have experienced obstetric violence, what I learned from you (Excerpt from an interview, Magnólia).

In each of the excerpts, it is identified that obstetric violence generated discomfort in these women, to the extent that the act of opening up during the conversation circles and sharing such intimate and painful moments with us had an impact both on their awareness of the processes that they and others went through, as well as on the

development of coping strategies and empowerment of these women. Speaking to other women about the violence each one was subjected to was an act of great courage, considering that, in some cases, they needed many years to process and share with family members about what happened. Furthermore, the exchange of experiences among women also fostered a movement of welcome and support, allowing them to realize that these violences did not occur because of them, but as a result of a series of determinants and intersections of power-knowledge relations, which promote disrespectful practices.

FINAL CONSIDERATIONS

Throughout this work, it was possible to explore the complexities of obstetric violence, recognizing its multifaceted nature. Although the topic has recently been brought into discussions, there is still a long way to go in demystifying what obstetric violence really is, as well as the need to validate the suffering and abuses that women are subjected to. In view of this, its main objective was to deepen the understanding of the experiences of women living in the Alagoas countryside concerning this issue, highlighting the importance of understanding and addressing women's experiences during the childbirth and birth process in conjunction with their territoriality.

In general, the shared stories indicate common experiences among women, allowing for the learning of traumatic experiences they faced during the processes of gestation, childbirth, and the postpartum period. Many of these accounts highlighted the lack of communication and empathy from healthcare professionals, evidencing the need for a more humanized approach in obstetric care. The lack of informed consent and the disrespect for the choices of pregnant women emerge as recurring themes, emphasizing the importance of empowering women in the decision-making process regarding their bodies and the care of their children. Additionally, reports often mention invasive medical practices, unnecessary interventions, and various forms of discrimination, highlighting the need for a critical review of obstetric practices to ensure that care is woman-centered and in accordance with ethical principles and human rights. We believe that these reports contribute to raising awareness about obstetric violence, emphasizing the importance of creating a healthcare environment that promotes respect, dignity, and compassionate care during women's sexual and reproductive processes.

Finally, by bringing to light the experiences narrated by women, this research aimed to give voice to the victims of obstetric violence and promote an environment of listening and support. By sharing these narratives, together, these voices reinforce the urgency to educate, raise awareness, and take action to combat obstetric violence and highlight the importance of sharing experiences, using speech as a therapeutic tool. Addressing and

preventing the multiple forms of obstetric violence is fundamental to ensure that women receive the dignified and respectful care they deserve during the process of gestation, childbirth, and postpartum, preserving their physical, mental, and emotional health. Therefore, these narratives serve as a powerful reminder of the urgency for substantial reforms in the healthcare system, focusing on ensuring obstetric care that prioritizes the dignity, respect, and overall well-being of women.

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